1.0 General Report Overview

Effective October 1, 2017, The Michigan Department of Health and Human Services (MDHHS) has modified the functionality of the Financial Status Report (FSR) bundle. The modification to the FSR bundle is designed to increase reporting efficiency for the Community Mental Health Services Programs (CMHSPs) and the Prepaid Inpatient Health Plans (PIHPs). The FSR bundle will now allow FSR reporting specific to the needs of the reporting board. There are three FSR report types; CMHSP (Non-Medicaid reporting), PIHP (Medicaid/Affiliate CMHSP reporting) and Stand Alone (Detroit-Wayne, Oakland, Macomb). The selected FSR will only display the applicable report tabs, columns and rows.

Please note that the report tabs, columns and rows that are not applicable are hidden or relabeled to condense the FSR bundle. Additionally, the financial reporting instructions for each form within the FSR bundle have not been modified. All column, row, cell and formula references remain intact and should only be considered if applicable to the selected FSR.

The Financial Status Report (FSR) – Medicaid is a comprehensive report of all activity of the Community Mental Health Service Program (CMHSP), that is a Prepaid Inpatient Health Plan (PIHP), or the Regional Authority that holds the Medicaid Managed Specialty Supports and Services Concurrent 1115 and 1915(c)/(i) Waiver Program Contract (Medicaid Contract) with the Michigan Department of Health and Human Services (MDHHS). The FSR - Medicaid summarizes the revenues and expenditures related to the Medicaid Contract. The FSR – Medicaid will identify whether there is a net surplus or deficit prior to any redirection of funding. The FSR – Medicaid will also identify any funding redirected to provide supplement to other programs for services to Medicaid consumers or redirected to address a deficit in funding.

> ***Note**: Per Public Act 2 of 2021 Sec 251 (1), the specialty managed care capitation payments include the direct care wage premium pay increase identified in MSA L 21-30. As a result, the Medicaid, including MI Health Link, direct care wage revenue and expenditures are reported in the FSR- Medicaid.*

The FSR – Medicaid will be utilized by the MDHHS, in conjunction with the other components of the FSR Bundle, as a tool to monitor the fiscal operations of the PIHP/CMHSP. In addition, this report will provide the basis for the annual contract reconciliation and cash settlement of the Medicaid Contract.

The PIHP/CMHSP shall comply with Generally Accepted Accounting Principles, along with any other federal and state regulations as defined in the Medicaid Contract. With the exception of the GF Contract - Special Fund Account – Section 226(a) of the Mental Health Code (MHC), all revenue and expenditures are required to be reported on an accrual basis of accounting, unless otherwise directed by MDHHS policy. As such, the revenue and expenditure amounts reported must include all earned reimbursements and/or obligations regardless of whether they have been billed or collected. Additionally, any adjustments for

uncollectible amounts or write-offs should be taken into consideration. The FSR –Medicaid must reconcile to the PIHP/CMHSP's general ledger.

The PIHPs with affiliate CMHSP contracts for the provision of the Medicaid benefit will report summary level revenue and expenditure information in separate columns for each contract. The amounts reported by the PIHP on the FSR – Medicaid should reconcile to the FSR – All Non-Medicaid – Section I – PIHP to Affiliate Medicaid Services Contracts for each affiliate CMHSP. The MDHHS may request, for select PIHPs, the reporting of prime sub-contractors in the separate columns.

The PIHP/CMHSP must certify the accuracy and completeness of the FSR –Medicaid and identify a contact person, phone number and email address that questions regarding the submission should be directed to. Please refer to the Electronic Report Submission Guidance and Report Certification Form.

2.0 Report - Due Dates

Refer to the reporting grid incorporated in Schedule E of the Contract for identification of report due dates. The reporting grid can be found on the MDHHS website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

3.0 Report Submission

3.1 Report Submitted via US Mail

This is no longer applicable. Electronic report submission required.

3.2 Report Submission – Electronic

The report should be submitted electronically to the department by the due date identified in 2.0 above at MDHHS-BHDDA-Contracts-MGMT@michigan.gov.

The report's file name must identify the reporting fiscal year, period covered (submission type), agency name, report title and date of submission. Example: For the FY XX Year End Interim submitted from network180 for the Medicaid FSR, the file name should read **FYXX Year End Interim network180 FSR Bundle MM-DD-YYYY.**

Note: The FSR– Medicaid is included in the FSR Bundle. It is not a stand-alone report.

Refer to the Electronic Report Submission Guidelines for report submission specifications.

4.0 Report Specific Navigation or Terminology

Within this document the terms used in these instructions shall be construed and interpreted as defined below:

Medicaid Contract: The Medicaid Managed Specialty Supports and Services Concurrent 1115 and 1915(c)/(i) Waiver Program Contract with selected PIHPs to manage the Concurrent 1115, 1915(c)/(i)Waiver and the Healthy Michigan Plan Programs in a designated service area and to provide a comprehensive array of specialty mental health and substance abuse services and supports.

Healthy Michigan Plan: The Healthy Michigan Plan is a new category of eligibility authorized under the Patient Protection and Affordable Care Act and Michigan Public Act 107 of 2013 that began April 1, 2014.

Autism Benefit - The MDHHS/PIHP Medicaid Managed Specialty Supports and Services Concurrent 1115 and 1915(i) Waiver Program, specifically via EPSDT authority, authorizes the Autism Benefit.

MI Health Link: MI Health Link is a new demonstration health care option authorized under Section 2602 of the Patient Protection and Affordable Care Act for Michigan adults, age 21 or older, who are enrolled in both Medicare and Medicaid (dual eligible).

GF Contract: MDHHS/CMHSP Managed Mental Health Supports and Services Contract

PIHP: A CMHSP or Regional Authority that holds the Medicaid Managed Specialty Supports and Services Concurrent 1115 and 1915(c)/(i) Waiver Program Contract with MDHHS and acts as the Prepaid Inpatient Health Plan.

CMHSP: Community Mental Health Services Program that holds the GF Contract with MDHHS.

Regional Authority: An entity, jointly governed by the sponsoring CMHSPs, that has met the MDHHS requirements for selection to be certified to the Center for Medicare and Medicaid Services as a PIHP.

Medicaid Consumer: A Medicaid beneficiary who requires the Medicaid services included under the 1115 and 1915(c)/(i)Waiver Program; or who is eligible for the Healthy Michigan Plan.

IPA: Insurance Provider Assessment Act. Public Act 175 of 2018 created the Insurance

Provider Assessment Act. The legislation mandates that effective October 1, 2018, certain insurance providers are required to pay an assessment on certain paid health care revenue.

Substance Use Disorder (SUD): A combination of the federal grant received by the State from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the general fund dollars appropriated by the legislature for the prevention and treatment of SUD.

Direct Care Wage (DCW): Per Public Act 2 of 2021 Sec 251 (1), an hourly wage increase (referred to as "Premium Pay") in direct care worker wages in response to the COVID-19 state of emergency as identified in MSA L 21-30.

The Financial Status Report - Medicaid includes cell shading to assist the end user with completion of the form.

Report headers are shaded in light green.

Cells requiring data entry are shaded in yellow.

Cells that are formula driven and should not have data entered are shaded peach or light turquoise. The cells shaded in light turquoise represent sub-totals or totals.

Select cells have conditional formatting applied so that if an erroneous entry is made the cell will turn orange.

Worksheet protection has been enabled.

Precision as displayed functionality has been enabled. As such, Excel will utilize the displayed value instead of the stored value when it recalculates formulas.

The term "Submission Type" on the worksheet refers to the reporting period, i.e. Projection, Interim, Final.

The following numbering / sequencing have been utilized in the FSR Medicaid:

1	Row for entry of the name of the PIHP or CMHSP for each column
100	Title row for revenue
101-189	Detail rows for reporting revenue. May include sub-totals.
190	Total row for revenue
200	Title row for expenditures
201-289	Detail rows for reporting expenditures. May include sub-totals.
290	Total row for expenditures

295	Sub-total row identifying net surplus (deficit) prior to any redirection
300	Title row for redirection of funds (TO) and FROM
301-389	Detail rows for reporting redirection. May include sub-totals.
390	Total row for redirection of funds (TO) and FROM
400	Total row identifying the remaining balance. The balance is calculated by taking into consideration available revenue less expenditures and adjusting for any redirections (TO) or FROM. This row will indicate whether there is a remaining balance impacts fund balance, savings or lapse.
401	Total row identifying the direct care wage remaining balance. The balance is calculated by taking into consideration available revenue less expenditures. This row will indicate whether there is a net surplus or deficit.

The FSR Medicaid

Column A is to be used by the reporting PIHP for the revenues, expenditures incurred by the PIHP. Additionally, the PIHP will use Column A to report all redirection of funds.

Column B through H – Page 1: Column B through H will be used by the PIHP to report summary level information of their contracts with affiliate CMHSPs for the provision of the Medicaid benefits. The amounts reported by the PIHP should reconcile to the revenues, expenditures, redirection of funds, sub-totals and totals for the affiliate CMHSPs.

Column I: Column I is formula driven and represents the total of revenues, expenditures and redirections entered in Columns A through H – Page 1 and Columns J through R – Page 2.

Column J through R – Page 2: With the formation of Regional Authorities the number of affiliate CMHSPs has increased. To facilitate reporting, a second page has been added to the FSR - Medicaid.

Columns J through R, found on the second page of the FSR – Medicaid, will be used by the PIHP to report summary level information of their contracts with affiliate CMHSPs for the provision of the Medicaid benefits. The amounts reported by the PIHP should reconcile to the revenues, expenditures, redirection of funds, sub-totals and totals of the affiliate CMHSPs.

The FSR - Medicaid – Row Layout: For the most part, all rows contain an alpha reference, a numeric reference, a description, and then the amount associated to the listed elements. The alpha reference refers to the Section of the FSR (Medicaid). The number reference refers to the character of the line (revenue, expenditures, etc.). The description could be a label (revenue, expenditure, etc.) or a more detailed description of the item (State Plan (B),

State Plan (b)(3), etc.). The redirection rows include at the end of the description a reference to the partner row.

For example – A 301 (TO) CHMSP to CMHSP Earned Contracts – J 304, the "A" refers to Medicaid, the 301 indicates that this row represents a redirection to another row, the "(TO) CMHSP to CMHSP Earned Contracts" describes that Medicaid funds are being redirected to CMHSP to CMHSP Earned Contracts, the "J 304" indicates that the partner row (FROM row) is in Section J – CMHSP to CMHSP Earned Contracts, row 304 on the FSR – All Non-Medicaid.

REDIRECTS – (TO) FROM – Each PIHP/CMHSP is expected to maintain a balanced budget. However, it is acknowledged that funding and expenditures, by category may not always be equal. The "Redirected Funds (To) From" section will be the mechanism in which the PIHP/CMHSP will identify how any funding surplus or deficit was resolved. The "redirects" will identify how surplus funds are used by other programs or how deficits were covered by other funding sources. In either case, the funding source must be a legitimate source of funding for the program the funding is being redirected to cover.

The redirection of GF to Medicaid requires prior approval of the MDHHS.

Every "TO" redirection will have an offsetting "FROM" transaction. The converse is also true, for every "FROM" redirection there will be a "TO" transaction. The "TO" and "From" amounts will be equal; thus, all redirections will sum to zero. Following is an example:

A 333 (FROM) Risk Corridor – PIHP Share – N 301 $100,000

This line is within the FSR – Medicaid and indicates that $100,000 is being transferred "FROM" the FSR – All Non-Medicaid – Risk Corridor Section to fund the PIHP share of a funding deficit.

N 301 (TO) Medicaid Services – PIHP Share – A 333 ($100,000)

This line is within the FSR – All Non-Medicaid – Risk Corridor Section and indicates that $100,000 is being redirected "(TO)" the FSR – Medicaid to fund the PIHP share of a funding deficit.

Redirection amounts are entered in the FROM redirects and automatically linked to the TO redirects as the opposite or converse amount.

5.0 Instructions for Completion of the Report

The PIHP name, Fiscal Year, Submission Type and Submission Date have been brought forward from the Medicaid Contract Settlement Worksheet.

Row 1 – PIHP or CMHSP

Enter in column A the name of the Regional Authority / Reporting Board. Enter in columns B through H – Page 1 and columns J through R – Page 2 the names of any affiliate CMHSP. As previously mentioned, the MDHHS may request, for select PIHPs, the reporting of prime sub-contractors.

Row A – MEDICAID SERVICES – PIHP USE ONLY
This row is the label MEDICAID SERVICES – PIHP ONLY. The rows immediately following will represent the revenues, expenditures and redirection of funding related to the provision of the Medicaid benefit.

Row A-100 – REVENUE
This row is the label REVENUE. The rows immediately following will represent the revenues available to fund current year expenditures.

> ***Note**: Effective FY20, the quarterly HRA Medicaid revenue should **not** be reported with Medicaid; row (A 125) should be utilized.*

Row A-101 – SPECIALTY MANAGED CARE MEDICAID REVENUES
Column A, in this row, represents the amount of funding authorization associated to the Mental Health and Substance Abuse Medicaid – Specialty Managed Care capitated payments, inclusive of any open accruals. This cell is formula driven. The formula is *plus Medicaid Contract Settlement Worksheet – Total Medicaid Revenue – Current Year Settlement (1.i) – columns – Medicaid, Children's Waiver, SED, HSW, and DHIP.*

Row A-115 - MEDICAID MANAGED CARE - AFFILIATE CONTRACTS – COLUMN A
This cell is formula driven and will offset the revenue distributed to each of the affiliates recognized in columns B through H – Page 1 and columns J through R – Page 2. The formula is *less the amounts reported in Columns B through H – Page 1 and columns J through R – Page 2.*

Row A-115 – Medicaid Managed Care – Affiliate Contracts – Column B through H – Page 1 and Column J through R – Page 2
Enter the amount of funding distributed to each of the affiliate CMHSPs of the PIHP.

Row A-116 – DIRECT CARE WAGE – COLUMN A
Column A, in this row, represents the amount of direct care wage funding retained by the PIHP. This cell is formula driven and is offset by the revenue distributed to each of the affiliates recognized in column B through H – Page 1 and column J through R – Page 2. The formula is *the sum of Medicaid Contract Settlement Worksheet – MDHHS - Direct Care*

Wage Revenue – Totals – columns Medicaid, Children's Waiver, SED, and HSW (2.d) less the sum of the amounts auto-populated in column B through H – Page 1 and column J through R – Page 2.

Row A-116 – Direct Care Wage Column B through H - Page 1 and Column J through R – Page 2

The amounts in column B through H – Page 1 and column J through R – Page 2 represent the amount of direct care wage funding distributed to each of the affiliate CMHSPs of the PIHP. The cells are formula driven. The formula is *plus Expenditure – Direct Care Wage (A 206).*

Row A-120 - SUBTOTAL - CURRENT PERIOD MEDICAID SERVICES REVENUE

These cells represent the total of Medicaid capitated payments and/or distribution of revenue to the affiliate CMHSPs. The cells are formula driven. The formula is *the sum of Specialty Managed Care Medicaid Revenue (A 101), Medicaid Managed Care – Affiliate Contracts (A 115) and Direct Care Wage (A 116).*

Row A-121 - 1ST & 3RD PARTY COLLECTIONS - MEDICARE/MEDICAID CONSUMERS REPORTING BOARD

The PIHP/CMHSP is the payer of last resort and has the responsibility to identify and seek recovery from all other parties for services provided to recipients. Enter, in Column A, the funding available to the Reporting Board from 1st and 3rd party collections (consumer fee payments, insurances and Medicare) that are not included in the Special Fund Account authorized in Section 226a (PA423) of the Mental Health Code (MHC) or enrolled in the MI Health Link program. The 1st and 3rd party collections for the MI Health Link enrollees are to be entered on the FSR - MI Health Link. The amount entered in this cell is for 1st and 3rd party collections associated to the cost of a person's 100% funded daily care or services.

Row A-122 - 1ST & 3RD PARTY COLLECTIONS - MEDICARE/MEDICAID CONSUMERS - AFFILIATE

The PIHP/CMHSP is the payer of last resort and has the responsibility to identify and seek recovery from all other parties for services provided to recipients. Enter, in columns B through H- Page 1 and columns J through R – Page 2, the funding available to the affiliate CMHSP from 1st and 3rd party collections (consumer fee payments, insurances and Medicare) that are not included in the Special Fund Account authorized in Section 226a (PA423) of the Mental Health Code (MHC) or enrolled in the MI Health Link program. The 1st and 3rd party collections for the MI Health Link enrollees are to be entered on the FSR - MI Health Link. The amount entered in this cell is for 1st and 3rd party collections associated to the cost of a person's 100% funded daily care or services.

> ***Note**: The amounts reported for affiliate 1st and 3rd party are for reporting purposes only and will not be included in the general ledger of the PIHP/CMHSP. These amounts will not be taken into consideration of the contract reconciliation and cash settlement.*

Row A-123 - PRIOR YEAR MEDICAID SAVINGS (FUNDING CURRENT YEAR EXPENSES)
This cell represents the amount of earned Medicaid savings from the prior fiscal year (FY) that is being utilized to fund current year expenditures. This cell is formula driven. The formula is *plus Medicaid Contract Settlement Worksheet – Current Year Expenditures – Medicaid, Total column (5.b).*

Row A-124 - ISF ABATEMENT
Enter, in Column A, the amount of Internal Service Fund (ISF) - Abatement that is being utilized to fund current year expenditures due to over funding of the ISF.

Row A-125 – Psych Hospital Rate Adjuster (HRA)
Enter, in Column A, the amount of revenue received for the psychiatric inpatient hospital rate adjustment.

Row A-140 - SUBTOTAL - OTHER MEDICAID REVENUE
These cells represent the total Other Medicaid Revenue available to fund current year expenditures. This cell is formula driven. The formula is the *sum of 1st & 3rd Party Collections – Medicare/Medicaid Consumers – Reporting Board (A 121), 1st & 3rd Party Collections – Medicare/Medicaid Consumers – Affiliate (A 122), Prior Year Medicaid Savings (Funding Current Year Expenses) (A 123), ISF Abatement (A 124) and Psych Hospital Rate Adjuster (HRA) (A 125).*

Row A-190 - TOTAL REVENUE
These cells represent the total Medicaid services revenue available to fund current year expenditures. These cells are formula driven. The formula is the *sum of the Sub-total – Current Period Medicaid Services Revenue (A 120) and the Subtotal – Other Medicaid Revenue (A 140).*

Row A-200 – EXPENDITURE
This row is the label EXPENDITURE. The rows immediately following will represent the expenditures for services provided and authorized in the Medicaid Contract.

Row A-201 - PIHP Insurance Provider Assessment (IPA) Tax
Enter, in Column A, the amount of accrued expenditures associated to the Medicaid Insurance Provider Assessment (IPA) Tax.

Row A-202 - MEDICAID SERVICES
Enter the amount of expenditures related to the provision of services to Medicaid consumers as authorized in the Medicaid Contract.

Row A-203 - PAYMENT INTO MEDICAID ISF
Enter, in Column A, the amount of expenditures related to the contribution (deposit) into the Medicaid ISF. All deposits into the ISF must meet the criteria established in the ISF Technical Requirement of the Medicaid Contract.

Row A-204 – PSYCH HOSPITAL RATE ADJUSTER (HRA)
Enter, in Column A, the amount of expenditures related to the psychiatric inpatient hospital rate adjustment.

Row A-205 – MI Health Link – Medicaid Services
Enter, in Columns A through R, the amount of expenditures related to the provision of Medicaid services to individuals enrolled in MI Health Link who are Medicaid eligible.

> ***Note***: *Reporting on row A 205 of the FSR – Medicaid is limited to the cost of providing Medicaid services to individuals enrolled in MI Health Link. The cost of providing Medicare services that are funded with Medicare are reported on the FSR - MI Health Link. If Medicare funding is not sufficient, the PIHP can use current year Medicaid to supplement. The current year Medicaid utilized to supplement MI Health Link would be redirected to MI Health Link and reported on the FSR –Medicaid row A 301c and the FSR – MI Health Link row AK 310.*

Row A-206 – DIRECT CARE WAGE
Enter the amount of Medicaid, including MI Health Link, expenditures related to the direct care wage increase as authorized in MSA L 20-28 and L 20-42.

Row A-290 - TOTAL EXPENDITURE
These cells represent the total Medicaid services expenditures prior to any redirects. These cells are formula driven. The formula is the *sum of PIHP Insurance Provider Assessment (IPA) Tax (A 201), Medicaid (A 202), Payments into Medicaid ISF (A 203), Psych Hospital Rate Adjuster (A 204), MI Health Link – Medicaid Services (A 205) and Direct Care Wage (A 206).*

Row A-295 - Subtotal Net MEDICAID SERVICES SURPLUS (DEFICIT)
These cells represent the net Medicaid surplus or deficit before any redirection of funds. These cells are formula driven. The formula is *Total Revenue (A 190) less Total Expenditure (A 290).*

Row A-300 - REDIRECTED FUNDS (TO) FROM
This row is the label Redirected Funds (TO) FROM. The rows immediately following will identify how surplus funds were used by other funding programs or how deficits were covered by other funding sources. In either case, the funding source must be a legitimate source of funding for the program the funding is being redirected to cover.

Row A-301 - (TO) CMHSP TO CMHSP EARNED CONTRACTS - J304
This cell represents the amount of Medicaid funds that are being redirected to cover the cost of services provided to Medicaid beneficiaries above the earned CMHSP to CMHSP Earned Contract revenue. The cell is formula driven. The formula is *less FSR – All Non-Medicaid – Section J – CMHSP to CMHSP Earned Contracts – FROM Medicaid Services (J 304).*

Row A-301a – Intentionally Left Blank

Row A-301b - (TO) HEALTHY MI PLAN – AI 310.
This cell represents the amount of *current year* Medicaid funds that are being redirected to cover the cost of services provided to Healthy Michigan beneficiaries above the Healthy Michigan capitation. The cell is formula driven. The formula is *less FSR – Healthy Michigan – From Medicaid (AI 301b).*

> ***NOTE:*** *The funding priority, for federal funding, established in FY 17 relative to Medicaid and Healthy Michigan funds are indicated below:*
>
> *If a shortfall in Medicaid or Healthy Michigan exists, surplus current year Medicaid or Healthy MI Plan funding should be utilized first, if a shortfall still exists then the Medicaid or Healthy MI Plan ISF.*

Row A-301c - (TO) MI HEALTH LINK SERVICES (MEDICARE) – AK 310.
This cell represents the amount of *current year* Medicaid funds that are being redirected to cover the cost of services provided to MI Health Link - Medicare beneficiaries above the Medicare received from the Integrated Care Organization (ICO). The cell is formula driven. The formula is *less FSR – MI Health Link – From Medicaid (AK 310).*

Row A-302 - FROM CMHSP TO CMHSP EARNED CONTRACTS - J301 (explain - section AB).
Enter, in Column A, the amount of any surplus in CMHSP to CMHSP Earned Contracts related to the provision of services to Medicaid beneficiaries being redirected to Medicaid. A brief explanation should be included in Section AB identifying the rationale of this transaction.

Row A-303 - FROM NON-MDHHS EARNED CONTRACTS - K301 (explain - section AB)
Enter, in Column A, the amount of any surplus Non-MDHHS Earned Contract funding associated to the provision of services to Medicaid beneficiaries being redirected to Medicaid. A brief explanation should be included in section AB identifying the rationale of this transaction.

Row A-310a - FROM HEALTHY MI PLAN - AI301.a
Enter, in Column A, the amount of any Healthy MI Plan funding associated to the provision of services to Medicaid beneficiaries being redirected to Medicaid.

> ***NOTE:*** *The funding priority, for federal funding, established in FY 17 relative to Medicaid and Healthy Michigan funds are indicated below:*
>
> *If a shortfall in Medicaid or Healthy Michigan exists, surplus current year Medicaid or Healthy MI Plan funding should be utilized first, if a shortfall still exists then the Medicaid or Healthy MI Plan ISF.*

Row A-315 - From Restricted Fund Balance – RES 1.c
This cell represents the amount of restricted fund balance being redirected to fund all or a portion of the net Medicaid services expenditures. This cell is formula driven. The formula

is *less the sum of RES Fund Bal - Restricted Fund Balance Activity (1.c) – Column: PA2 and Column: Performance Bonus Incentive Pool (PBIP).*

Row A-325 – Info Only – Affiliate Total Redirected Funds – I390
This data is being collected for informational purposes only and will assist in identifying the overall funding associated to the cost of providing services to Medicaid consumers for Medicaid covered benefits. Enter the amount of redirected funds, at the affiliate level, being utilized to fund all or a portion of the net Medicaid services deficit.

Row A-330 - Subtotal Redirected Funds – rows 301 – 325
This cell represents the subtotal of redirected funds to or from the FSR – All Non-Medicaid to Medicaid services prior to any redirections for an overall funding deficit. The cell is formula driven. The formula is the *sum of (TO) CMHSP to CMSHP Earned Contracts (A 301), Intentionally left blank (A 301a), (TO) Healthy MI Plan (A301b), (TO) MI Health Link Services (Medicare) (A 301c), FROM CMHSP to CMHSP Earned Contracts (A 302), FROM Non-MDHHS Earned Contracts (A 303), Intentionally left blank (A 310), FROM Healthy MI Plan (A 310a), FROM Restricted Fund Balance (A315) and Info Only – Affiliate Total Redirected Funds (A 325).*

Row A-331 - FROM GENERAL FUND - REDIRECTED TO UNFUNDED MEDICAID COSTS - B301
Enter, in Column A, the amount of redirected general funds (GF) being utilized to fund all or a portion of the net Medicaid services deficit. This amount must have prior approval from the MDHHS as part of the PIHP's risk management plan.

Row A-332 - FROM LOCAL FUNDS - M**301**
Enter, in Column A, the amount of Local funds being utilized to fund all or a portion of the net Medicaid services deficit.

Row A-333 - FROM RISK CORRIDOR - PIHP SHARE - N**301**
This cell represents the amount of Stop/Loss Insurance and/or ISF funds being utilized to fund all or a portion of the net Medicaid services deficit. This cell is formula driven. The formula is *less Medicaid ISF - ISF Balances / Current Activity (1.a) – Column: Current Period ISF Financing Medicaid (Risk)*.

> ***NOTE:*** *The funding priority, for federal funding, established in FY 17 relative to Medicaid and Healthy Michigan funds are indicated below:*
>
> *If a shortfall in Medicaid or Healthy Michigan exists, surplus current year Medicaid or Healthy MI Plan funding should be utilized first, if a shortfall still exists then the Medicaid or Healthy MI Plan ISF.*

Row A-334 - FROM RISK CORRIDOR - MDHHS SHARE - N**302**
Enter the amount of MDHHS funds being utilized to fund the MDHHS share of the net Medicaid services deficit.

ROW A-335 - FROM RESTRICTED FUND BALANCE – RISK FINANCING RES 1.C
This cell represents the amount of restricted fund balance being utilized to fund all or a portion of the net Medicaid services deficit. This cell is formula driven. The formula is *less the sum of RES Fund Bal - Restricted Fund Balance Activity (1.c) – Column: PA2 – (Risk Financing) and Column: Performance Bonus Incentive Pool (PBIP) – (Risk Financing).*

ROW A-390 - TOTAL REDIRECTED FUNDS
These cells represent the total of redirected funds associated to Medicaid services. These cells are formula driven. The formula is the *sum of Subtotal Redirected Funds (A 330), FROM General Fund – Redirected to Unfunded Medicaid Costs (A 331), FROM Local Funds (A 332), FROM Risk Corridor – PIHP Share (A 333), FROM Risk Corridor – MDHHS Share (A 334) and FROM Restricted Fund Balance – Risk Financing (A 335).*

ROW A-400 - BALANCE MEDICAID SERVICES
These cells represent the net Medicaid surplus or deficit after redirection of funds. There should never be a deficit, as the PIHP identifies how the deficit was resolved utilizing the redirect section of the FSR. Any amounts greater than zero (surplus) reflected in this cell (column A and column I) will represent unspent Medicaid funding. The Contract Reconciliation and Cash Settlement process will determine whether any unspent Medicaid funding will be earned Medicaid Savings or lapsed to the MDHHS. These cells are formula driven. The formula is *Subtotal Net Medicaid Services Surplus (Deficit) (A 295) plus Total Redirected Funds (A 390) less Balance Medicaid Direct Care Wage Services (A 401).*

> ***NOTE**: Column A – Reporting Board and Column I – PIHP Grand Total page 1 & 2 are the only columns that should have amounts greater than zero. All other columns should equal zero.*

ROW A-401 - BALANCE MEDICAID DIRECT CARE WAGE SERVICES
These cells represent the net Direct Care Wage surplus or deficit. Any amounts greater than zero (surplus) reflected in this cell (column A and column I) will represent the net unspent direct care wage funding. Any amounts less than zero (deficit) reflected in this cell (column A and column I) will represent the net costs above the direct care wage funding. The Contract Reconciliation and Cash Settlement process will identify the Direct Care Wage funding that will be lapsed to the MDHHS. These cells are formula driven. The formula is *Direct Care Wage (A 116) less Direct Care Wage (A 206).*

> ***NOTE**: Column A – Reporting Board and Column I – PIHP Grand Total page 1 & 2 are the only columns that should have amounts. All other columns should equal zero.*

ROW AB – REMARKS
This section has been provided for the PIHP to provide narrative descriptions as necessary. If this space is insufficient, please utilize the "Additional Narrative" tab within the FSR Bundle.